		X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	TIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILD	ING	01	COMPLI	ETED	
		155207	B. WING	1110		11/09/	2012	
				STREET A	ADDRESS, CITY, STATE, ZIP CODE	<u> </u>		
NAME OF PROVIDER OR SUPPLIER								
NEW HAVEN CARE & REHABILITATION CENTER			1201 DALY DR					
NEW DA	VEN CARE & REDA	ABILITATION CENTER	NEW HAVEN, IN 46774					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION			(X5)		
PREFIX			P	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		TE	COMPLETION	
TAG				TAG	DEFICIENCY)		DATE	
K0000								
	A Life Safety Code Recertification, State		K0000 This plan of correction is					
	Licensure and Q	·	prepared and executed because					
	-	-			it is required by the provisions	of		
		y were conducted by the			the state and federal law and i	not		
		partment of Health in			because New Haven Care and	t		
	accordance with	42 CFR 483.70(a).			Rehabilitation agrees with the			
					allegations and citations listed	on		
	Survey Date: 11	/09/12			pages 1 through 13 of this			
					statement of deficiencies. Nev			
	E 117 N 1	000114			Haven Care and Rehabilitation	ו		
	Facility Number				maintains that the alleged			
	Provider Numbe	r: 155207			deficiencies do not jeopardize			
	AIM Number: 1	00266640			health and safety of the reside			
					nor are they of such character as to constitute substandard	so		
	Surveyor: Ioe L	. Brown, Jr., Life Safety			quality of care or limit our			
	_	. Drown, 31., Elie Surety			capability to render adequate			
	Code Specialist				care. Please accept this plan	of		
					correction as our credible	· .		
	At this Life Safe	ty Code survey, New			allegation of compliance.New			
	Haven Care & R	ehabilitation Center was			Haven Care and Rehabilitation	n is		
	found not in com	inliance with			also requesting Desk Review,			
	Requirements fo	-			Paper Compliance for the alleg	ged		
	_	aid, 42 CFR Subpart			deficiencies from our recent			
		*			annual Life Safety survey.K-00			
	` / '	Safety from Fire and the			SS=E & K-0066 SS=DNovemI			
	2000 edition of t	he National Fire			26, 2012Dennis Austill Life Sa	-		
	Protection Assoc	ciation (NFPA) 101, Life			SupervisorDivision of Long Te	rm		
	Safety Code (LS	C), Chapter 19, Existing			Care2 North Meredian			
		upancies and 410 IAC			StreetIndianapolis, IN			
		upaneles and 410 IAC			46204Request for Desk Revie of the following Deficiencies lis			
	16.2.				on our recent 2567 following	งเซน		
	This one story facility was determined to be of Type V (000) construction and was				annual Life Safety survey.Dea	,		
					Dennis: Thank you for taking			
					time to review the recently			
	• • •	. The facility has a fire			submitted 2567, from New Ha	ven		
		th smoke detection in the			Care and Rehabilitation Cente			
	-				New Haven, Indiana. I am			
	corridors and ar	eas open to the corridors			requesting desk review			
1			1		İ			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

JO9C21

Facility ID:

000114

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		IDENTIFICATION NUMBER:	a. Building 01			COMPLETED	
	155207		B. WING 11/09/2012			11/09/2012	
			b. WIIV		ADDRESS, CITY, STATE, ZIP CODE		\dashv
NAME OF PROVIDER OR SUPPLIER			1201 DALY DR				
NEW HAVEN CARE & REHABILITATION CENTER			NEW HAVEN, IN 46774				
NEW HAVEN CARE & REHABILITATION CENTER				INLVVII	AVEN, IN 40774		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
	with hard wired	smoke detectors in the			compliance as I feel that the		
	resident rooms.	The facility has a			citations were isolated events,		
	capacity of 110 a	and had a census of 97 at			with corrections immediately taken to correct those		
	the time of this s				deficiencies. I do not believe the	nat	
		ar vey.			any residents' were harmed by		
	The feether	f4 i1ii4b			the deficiencies, validating my		
	_	found in compliance with			request for a desk review.Staff	;	
		rd to sprinkler coverage			was in serviced, and re-educa	I	
	and smoke detec	etor coverage.			related to proper disposal of		
					smoking materials by the		
	All areas where	the residents have			Maintenance Director and DNS		
	customary acces	s were sprinklered. All			11/26/12. The facility takes price		
		facility services were			in the fact that we represented		
	1 0	•			very well during the survey		
	_	ept a wood maintenance	process, and continue to be compliant in all other areas.An				
		n the facility which			auditing control system was pu	I	
	housed the gener	rator.			into place for review of the		
					deficiencies listed in the 2567	to	
	Quality Review by	Robert Booher, Life Safety			identify areas potentially at risl	c for	
	Code Specialist-Me	edical Surveyor on 11/15/12.			these types of findings. I am		
					pleased to announce that we		
	The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the				have maintained an excellent		
					record in all areas and provide	I	
					the highest quality of care. Thi evidenced by our yearly review		
					with very low percentage of	vs,	
	following:				complaints related to our facilit	v	
					over the last few years. I would	· I	
					greatly appreciate your		
					consideration into our request	for	
					desk review of this 2567. Pag	e	
					#1 of 2567 faxed to ISDH on		
					11/26/12. Respectfully		
					Submitted: David Holbrook		
					HFAAdministratorNew Haven Care and Rehabilitation		
					Care and Renabilitation		

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Event ID: JO9C21

Facility ID: 000114

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A DITT	LDING	01	COMPL	ETED
		155207	A. BUII B. WIN			11/09/2012	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER							
			1201 DALY DR NEW HAVEN, IN 46774				
NEW HAVEN CARE & REHABILITATION CENTER				NEW H	AVEN, IN 46774		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL					T.C.	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG		DEFICIENCY)	16	DATE
K0062	NFPA 101						
SS=E	LIFE SAFETY CO	DDE STANDARD					
	Required automa	tic sprinkler systems are					
		ntained in reliable operating					
	condition and are	inspected and tested					
	periodically. 19	0.7.6, 4.6.12, NFPA 13,					
	NFPA 25, 9.7.5						
	Based on observation	on and interview,	K00	062	Please see the attached plan correction for the Life Safety	of	11/29/2012
	the facility failed to	replace 1 of 3			Survey conducted at New Hav Care and Rehabilitation Cente		
	sprinklers in the nu	rses' station			on 11/09/2012. New Haven Ca		
	which were corrod	ed and loaded			and Rehab would respectfully request paper compliance on this plan of correction. These interventions were put into place	this	
	with accumulations	s of material.				ce	
	LSC 9.7.5 requires	all automatic			immediately following the investigation Implementations will be presented in the December, 2012 QA meeting and		
	sprinkler systems sh	all be inspected,					
	tested and maintain	ed in accordance			continue as an ongoing agend item. K 0062 SS=E 1. How wi ll		
	with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25,				the facility identify other residents having the potential		
					to be affected by the same		
					deficient practice? a. Resident's residing at the		
				facility have the potential to be			
	1998 edition, 2-2.1	.1 requires any			affected by the alleged deficient practice if the		
	sprinkler shall be re	placed which is			sprinkler head did not work properly, which was not the		
	painted, corroded,	damaged, loaded,			case. 2. What corrective action(s) will be accomplishe	ed	
	or in the improper	orientation. This			for those residents found to have been affected by the		
	deficient practice ha	ad the potential			deficient practice.b. No resident's were affected by the	10	
	to affect 34 resident	ts in the 200 hall			corrosion identified on the	10	
	where the nurse's st	ation is located			sprinkler head at the nurses station. This area is not utilized		

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Event ID: JO9C21

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BU	ILDING	01	COMPLETED	
155207		B. WI			11/09/2012		
NAME OF T	DOLUDED OF GURDI TO			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER				1201 D	ALY DR		
NEW HAVEN CARE & REHABILITATION CENTER			NEW HAVEN, IN 46774				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DESCRIPTION OF THE APPROPRIATE DESCRIPTION OF THE APPROPRIATE		(X5)	
PREFIX							
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	_	TAG DEFICIENCY)		DATE	
	in the event of an emergency.				by resident's at anytime and		
					resident's are not affected by	′	
					this alleged deficient practice.The Maintenance		
	Findings include:				Director immediately correct	ed he	
					the deficiency by cleaning th		
					corrosive material from the		
	Based on observation on 11/09/12				sprinkler head, which was		
	Dased on observation	OH 0H 11/09/12			minimal. He also replaced tw	o	
	with the Administra	ator during the			escutcheons.3. What Measur	es	
					will be put into place or what		
	tour from 9:19 a.m. to 11:58 a.m., one of the three sprinkler heads				systemic changes you will mal		
					to assure the deficient practice		
					does not recur? c. Maintenand Director will place on TELS	æ	
	directly above the r	nurses' station had			monitoring system, which		
	green corrosion around the frame of						
	green corrosion aro	dind the frame of			maintenance, and notifies the		
	the sprinkler head,	black					
					Administrator when preventati		
	accumulation of material around the deflector plate, and spider webs around the thermal linkage. The Administrator acknowledged there				maintenance is due. 4. How w the facility monitor its	''III	
					corrective actions to ensure		
					the deficient practice will not	:	
					recur? d. An Audit will be		
					conducted monthly by the		
		O			maintenance director to insur		
	was green corrosion	n around the			that all sprinkler heads are cle		
	frame of the sprinkl	ler head-black			of corrosion and/ or accumulated of materials on the sprinkler	IIOH	
	name of the spilliki	ici iicau, viack			heads.Contractor, J.O. Moury		
	accumulation of material around the				completes quarterly assessme	ents	
					as well of the sprinkler sytem a		
	denector plate, and	lector plate, and spider webs			heads for potential concerns		
	around the thermal	linkage of the			which are addressed immedia by the maintenance director.	tely	
	sprinkler head abov	head above the nurses'					
	station.						

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/27/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED				
155207			B. WING 11/09/2012					
NAME OF F	PROVIDER OR SUPPLIER	2	STREET ADDRESS, CITY, STATE, ZIP CODE					
NEW HAVEN CARE & REHABILITATION CENTER			1201 DALY DR NEW HAVEN, IN 46774					
					(VI)			
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX	(X5) COMPLETION				
TAG		LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	DATE			
	3.1-19(b)							

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Facility ID: 000114

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUII	DING	01	COMPL	ETED	
		155207	B. WING			11/09/2012		
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>		
NAME OF PROVIDER OR SUPPLIER								
NEW HAVEN CARE & REHABILITATION CENTER			1201 DALY DR NEW HAVEN, IN 46774					
NEW HAVEN CARE & REHABIEITATION CENTER								
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
K0066	NFPA 101							
SS=D	Smoking regulations are adopted and							
	include no less th	an the following provisions:						
	(1) Smoking is no	ohibited in any room, ward,						
		where flammable liquids,						
	·	es, or oxygen is used or						
	•	other hazardous location,						
		posted with signs that read						
	NO SMOKING or with the international							
	symbol for no sm	oking.						
		atients classified as not						
	•	phibited, except when under						
	direct supervision	l.						
	(3) Ashtrave of no	oncombustible material and						
		rovided in all areas where						
	smoking is permit							
	3 - 1							
	(4) Metal containe	ers with self-closing cover						
		h ashtrays can be emptied						
	•	ble to all areas where						
	smoking is permit							
	Based on observ	K00	K0066	K-0066 SS=D1. How will the		11/29/2012		
	facility failed to	ensure cigarette butts			facility identify other residen	ts		
	were deposited in	nto a noncombustible			having the potential to be			
	container which	was provided for 1 of 1			affected by the same deficier			
	areas where smo	king was permitted. This			practice? Resident's residing in the facility were not affected			
	deficient practice had the potential to				by the practice.2. What	zu		
	•	•			corrective action(s) will be			
	· ·	itilizing the designated			accomplished for those			
	employee smoking area adjacent to the resident dining area exit during a fire				residents found to have beer	1		
					affected by the deficient			
	emergency.				practice?No Residents or			
					employees were found to be			
	Findings include:				affected by the alleged			
	-				deficient practice.3. What			
	Rased on observ	ation on 11/09/12 with			Measures will be put into pla	ce		
	Dasca on ouserv	anon on 11/0/12 with						

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	OF CORRECTION IDENTIFICATION NUMBER: 155207	A. BUILDING B. WING	COMPLETED 11/09/2012	
	PROVIDER OR SUPPLIER AVEN CARE & REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL	STREET ADDRESS, CITY, STATE, ZIP CODE 1201 DALY DR NEW HAVEN, IN 46774 ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COMPLE		
TAG	the Administrator during the tour from 9:19 a.m. to 11:58 a.m., the smoking area is eleven feet away from the facility and adjacent to a nonsprinklered shed constructed of wood which was twenty feet from the building, had twenty five cigarette butts scattered about the staff bench seat area and throughout the grass area. Based on interview on 11/09/12 concurrent with the observations, the Administrator acknowledged the facility's employees disposed of cigarette butts on the ground and throughout the grass area instead of using the approved long neck vessel which was provided. 3.1-19(b)	or what systemic cha will make to assure the deficient practice does recur? The center state smoke at the center were-educated to ensure cigarette butts are planoncombustible contained the Maintenance Direct DNS 11/26/12/ The Administrator/or design complete an audit 3x/4 weeks, then weekly for weeks, and then more months.4. How will the monitor its corrective to ensure the deficient will not recur? The Administrator/or design complete an audit 3x/4 weeks, then 2x/wk for weeks, then weekly for weeks, then weekly for weeks, then weekly for weeks, and then more months. These audits reviewed at the next of the performance Improve Committee meeting for further recommendating will be ongoing as neafterward.	nges you ne es not es not es not es not es that aced in a ainer by ctor and gnee will week for or 4 thly for 3 ne facility es actions at practice gnee will week for or 4 thly for 3 se facility es actions at practice gnee will week for or 4 thly for 3 se will be monthly ement or any ions and	

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